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REDESIGNING THE CONTINENCE PATHWAY: THE RIGHT PATIENT WITH THE RIGHT PRACTITIONER

Hypothesis / aims of study

Following a successful bid for national public funding, our multidisciplinary continence team (consisting of hospital and community nurse specialists, a specialist pelvic floor physiotherapist, urology service manager, and sub-specialists in Female and Reconstructive Urology and in Uro-Gynaecology) set up a pilot study of a new local pathway for women with incontinence. The existing referral pathway was from primary care physicians to the clinic of one or other sub-specialist.

Our hypothesis was that most women presenting for the first time with urinary incontinence would be managed effectively by direct referral to a physiotherapist or specialist nurse, rather than a sub-specialist physician, and that patients could be identified who had complex problems that were best managed by prompt access to sub-specialist physicians.

The pathway aimed to shorten the patient journey, to reduce the demand for surgical intervention through effective conservative management, and to facilitate access to sub-specialist management. The two key components of the pathway were a new joint physiotherapist and specialist nurse clinic (PSNC), accessed rapidly via a protocol-driven referral, and a new joint clinic with sub-specialists in Female and Reconstructive Urology and in Uro-Gynaecology both present.

Study design, materials and methods

We agreed a pathway to permit direct access for patients from Primary Care into the PSNC. A proforma was designed and Primary Care physicians referred patients by fax. To reduce the risk of patients with complex problems coming to the PSNC, we agreed clinical markers of complex problems that should exclude the patient from the PSNC, and prompt assessment by a sub-specialist. These included haematuria, bladder pain, symptomatic prolapse, an abdominal or pelvic mass on examination, and previous lower urinary tract surgery. These risk factors were included on the referral proforma and the referring Primary Care physician was required to confirm that none of these were present, to allow access to the PNSC. A care pathway for conservative management was agreed, which comprised assessment by history (including the I-QOL and Urinary Incontinence Severity Score questionnaires) and clinical examination, and a management algorithm that included bladder training, pelvic floor exercises, lifestyle advice and the option of medication. Failure to respond at three months prompted referral to the joint clinic at the patient's request. The two sub-specialists identified suitable patients for management in the joint clinic from new referrals and some existing patients within their practices. Patients who failed to respond in the PSNC, and who wished to pursue further treatment were also seen after urodynamics. Details on all patients were recorded on a database.

Results

109 patients were referred to the PSNC. 15 with risk factors were referred onwards directly for gynaecology or urology investigation. 94 were invited to the nurse/physiotherapy clinic. 88 patients were assessed and treatment commenced. Over the three month period 23% of those assessed were lost to follow-up, 57 % found that their continence problems resolved or could be managed successfully by conservative therapies including medication. 18 patients (20% of those assessed) required urodynamic investigations and review at the joint clinic.

Of 119 joint clinic appointments offered, patients seen were as follows: 48 new, 54 follow-up (29 patients were seen twice, 2 four times), 3 men were inadvertently booked, and one lady was booked to the clinic in error. New patients seen were as follows: 34 primary care referrals, 4 each from urologists and gynaecologists, one colorectal referral, and 5 from the PSNC.

30 had stress urinary incontinence, 48, urge urinary incontinence, 11 mixed urinary incontinence, 26 had some form of pelvic pain and 21 prolapse (some patients had several symptoms). 23 were found to have haematuria.

Previous surgery was as follows: colposuspension 4, TVT 3, Stamey procedure 1, Macroplastique 2, hysterectomy 2, prolapse surgery 2. This gave 21% with previous incontinence surgery.

Outcomes were as follows: urodynamics 22, ambulatory urodynamics 2, Haematuria Clinic 9, other cystoscopy 7, physiotherapy 10, anticholinergics 18, Duloxetine 4, topical oestrogen 2, intravesical botulinum toxin injections 1, ring pessary 1, Pain Clinic 1, TVT 1, laparoscopy 1, laparoscopic repair 1, division of TVT 1.

Interpretation of results

This pilot study showed clearly that the majority of those women referred to the PSNC were managed effectively without the need for sub-specialist input, and that this part of the pathway allowed ready access to the sub-specialist clinic for those who failed to respond to initial management. The initial experience with the joint clinic showed that it was an effective way of providing multidisciplinary expert management.

Concluding message

A female continence pathway can be designed to reduce the patient journey from first identification of the problem to the provision of interventions, investigations and consultant opinion. A specialist nurse/physiotherapy led clinic can effectively assess, diagnose and manage different types of female urinary incontinence without the need for intrusive secondary investigations and make appropriate referral for urodynamic investigations and consultant review for those patients whose problems do not resolve with conservative therapies.

In the joint sub-specialist clinic, a relatively complex patient group has been seen. The clinic streamlines the patient pathway, and facilitates multidisciplinary discussion. The management has been somewhat conservative. All staff have seen this as an educational resource.

The initial experience has raised issues about further clinic development, including the involvement of specialties such as Pain Management and GU Medicine.

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